Health Information Technology Policy Committee
Final
Summary of the February 2, 2011, Meeting

KEY TOPICS

1. Call to Order

Judy Sparrow, Office of the National Coordinator (ONC), welcomed participants to the 20th meeting of the Health Information Technology Policy Committee (HITPC). She reminded the group that this was a Federal Advisory Committee meeting, and was being conducted with the opportunity for public comment. She asked Committee members to introduce themselves and turned the meeting over to David Blumenthal the National Coordinator for Health Information Technology and HITPC Chair.

2. Opening Remarks

Blumenthal explained that the ONC is trying to lay the framework for meaningful use Stage 2, including the associated interoperability, technology, and policy issues. He noted that he would be leaving this meeting early to be part of a Department of Health and Human Services (HHS) announcement on the initiation of exchange using the Nationwide Health Information Network (NHIN) Direct Project, which is now operational in two sites and will soon be operational in five or six additional sites. This is an important addition to the opportunities for exchange, and part of the overall escalator for meaningful use. NHIN Direct was developed with a very open collective, communal, voluntary process of joint software development informed by this Committee's Privacy and Security Tiger Team. It was closely integrated to ensure that the Direct solution was compatible with policies on privacy and security.

The ONC is still assessing the comments that were received on the Committee's ideas for meaningful use Stage 2 and has received numerous comments about the President's Council of Advisors on Science and Technology (PCAST) report.

3. Review of the Agenda

HITPC Vice Chair Paul Tang reviewed the day's agenda, and noted that he had a few corrections to the minutes from the last meeting, which he sent to Judy Sparrow.

> **Action Item #1:** Minutes from the December 13, 2010, HITPC meeting were approved by consensus, with corrections sent by Paul Tang to Judy Sparrow.

4. Quality Measures Workgroup Recommendations

Quality Measures Workgroup Co-Chair David Lansky reported on the responses the Workgroup has received from public input on the quality measures needed for meaningful use Stages 2 and 3. This group is working in a path that is parallel to the Meaningful Use Workgroup. Their comment period concluded a few weeks ago. He explained that the ONC wants to put into the refinement pipeline some of the best suggestions from this comment process. The goal of the discussion at this meeting is to provide feedback about whether this appears to be correct path, so that the Workgroup can move towards the processes that will create useable clinical quality measures by the end of this year in order to be part of the Stage 2 process.

The Quality Measures Workgroup has been asked to look outside the existing battery of measures, some of which are being retooled for e-health applications, and to examine the areas of patient engagement, safety, and care coordination, where there are not sufficient measures, and to very rapidly put some measures into the field. The HITPC needs to decide what a reasonable stress test for these would be.

Lansky noted that a Request for Proposals was issued in December, with a 1-month period set for responding. There were 134 responses from a very diverse and expert set of respondents, including researchers, state entities, and consumer organizations. It was a great success from the point of view of getting broad input. The criteria to select measures for Stages 2 and 3 include: (1) ready to be deployed rapidly, (2) HIT sensitive, (3) parsimonious approach, and (4) capture longitudinal performance over time. In addition, five measure domain areas were considered. These include patient and family engagement, clinical appropriateness/efficiency, care coordination, patient safety, and population and public health.

More than 1,000 recommended measures were received. The Workgroup synthesized those to 491 unique measure concepts; some are ready to go, others are simply ideas for consideration. Also, there are 113 existing measures that need to be retooled. The Workgroup's current task is to determine what the next cut is in order to reach a set of 20-40 measures that will become the pool for serious work over the next year or so.

Lansky presented the measures in each of the five areas, asking for Committee input after each.

Patient/Family Engagement

The most promising measures are in the areas of patient of experience of care, as measures by the CAHPS survey or something like it. Is the full CAHPS survey the tool to use for meaningful use?

Another promising set of measurements is in the area of functional status and health risk. Similar to patient experience, there are many instruments and measures, so it is a challenge to choose the best ones.

Patient activation and self-management skills is another area in which the job to select feasible and appropriate components from the many that exist.

There are methodology challenges. If the Workgroup were to pick and choose components, will that still be methodologically valid? Also, there are issues with the data platform. If they capture experience data in a clinical setting, it might not be unbiased. Also, with regard to sampling: do they try to capture all patients, or only a subset? Is this information captured via an e-mail survey platform, or through the electronic health record (EHR) itself? How would the relationship be configured between the EHR and this potentially separate collection service? If a sample of patients is used, how is that sample defined?

Discussion

- Christine Bechtel commented that shared decision-making is an important area, but it is a gap area. Also important are outcomes measures. Getting to improved patient outcomes is going to require patient/family engagement, and needs to include patient-reported information. The Workgroup will need to think through some data exchange capabilities, especially for meaningful use Stage 3. Lansky noted that many specialties may have patient outcome measures associated with their systems. It is feasible to imagine that some of the domains that Bechtel is describing could appear on those menu sets. Josh Seidman said that there are some decision quality measures that are promising, but they will not be ready for meaningful use Stage 2. They are working towards these for Stage 3.

- In response to a Committee question, Lansky said that the Workgroup is looking closely at the National Institutes of Health's (NIH) Patient-Reported Outcomes Measurement Information System (PROMIS) and the U.S. Food and Drug Administration's (FDA) attempt to capture patient-reported outcomes in clinical trials.

- Gayle Harrell emphasized the importance of the specialty measures. Bechtel noted that a lot of patient and family measures can apply across specialties.

Clinical Appropriateness and Efficiency

Lansky said that the most promising measures were lipid control, linked to the Framingham risk score. This involves the ability to titrate the measures against risk classes in an area. Someone in a higher risk for heart disease may get a different type of measure than others. This stratifying measurement represents a breakthrough from some of the broad population measures that existed before.

Another suggested area addresses the appropriateness of diagnostic imaging. There are several dimensions of those measures, including not having redundant tests and ordering the right tests. Quite a few measures were suggested. Several measures dealing with appropriate medication use, and the measure of both overuse and underuse, were also suggested.

Methodology problems include linking claims and administrative data to find out what medications were actually dispensed, and looking at previous imaging orders. Is that kind of linkage realistic? Also, the idea of allocating some of the measures to certain risk groups, as in Framingham, is another challenge they have not previously undertaken.

Discussion

- Larry Wolfe said that some of this is not just an outcomes problem, it also relates to decision processes and workflow. In order for tests to be appropriately ordered based on previous claims, the person ordering needs to know that it was ordered, and have access to previous results. There is a fair amount of undertow to this, in that the data platform is not just an outcomes reporting platform, but a care delivery platform.

- Lansky noted that these measures are intended to have the potential to pull through process redesign. If people are being held accountable for not ordering unnecessary tests, they will need to come up with the tools to do that. Whether this Committee needs to identify the tools for them to do so or just state the outcomes required is something to think about.

- David Blumenthal said that in his own practice, he avoided duplicate tests because he had a software package, now commercially available, which screened all the previous images in a record. It alerted him whenever something in 3 months was a duplicative test. That was an enormously powerful decision support tool. He did not have access to all the tests that a patient might have had, but he could at least find out if he or one of his immediate colleagues had ordered the test. For an oncologist, this is an especially powerful tool, because oncology is an enormous user of high-cost imaging with high radiation exposure. This would be a very novel safety addition to records.

- Charles Kennedy offered a caution about incorporating claims data. The proposed HIT-sensitive measure indicates that there should be evidence that electronic medical records (EMRs) can incorporate such data. He said they tried, and almost no vendors can support it. These are great measures, but he is not sure how the methodological issues will be dealt with.

- Blumenthal noted that there are technical challenges to combining clinical and claims data, and the big challenge is in getting clean data. A single clinical event is represented four times, on average, when clinical and claims data are combined.

Care Coordination

David Lansky said that the most promising measures that surface are adherence to a comprehensive care plan. He named the area of care transition in particular. This was captured in the methodology earlier in the area of family/patient engagement.

One area of measurement suggested was whether the patient felt they were fully engaged.

Composite measures include a comprehensive clinical summary after transition, with both clinicians and patients receiving patient summaries after a handoff of care.

Interoperability is not broadly available to assess care coordination. Just knowing whether a patient made it to their next destination is non-trivial right now. No "closing the loop" function is enabled today.

How is a longitudinal record standardized? There is nothing currently in place to help with this issue. Deep methodology work needs to be done here, so the question is, what are specifications? How are data linked across the multiple settings? How is a transition of care assessed? This may be a more challenging area than others, Lansky said.

Discussion

- Adam Clark suggested that not having a standardized plan and specific, defined elements in patient care documents may not be a bad thing. He worries about the notion of defining what the record should look like. Lansky said that they are driving at have the structure standardized, but not dictating that the content be the same. Josh Seidman said that they are having similar discussions in the Meaningful Use Workgroup, where they are trying to ensure that comprehensive care plans are meaningful for all parties involved and leave enough flexibility for innovation.

- Marc Probst asked whether "care transition" is well defined because there is a fairly broad understanding of what care transition is. Lansky acknowledged that this is a challenge they will have to take up.

- Judy Murphy noted that this is a totally different undertaking for large health care organizations versus a series of small organizations having to work together. In some areas of the country health care is provided by many small groups, pointing to the need for an increased emphasis on interoperability.

- Blumenthal explained that the ONC is working hard to reach the simplest, most practical, irreducible level of interoperability available as an option. The view is that whatever is being done by paper or fax should be possible to do electronically. Setting a target for this in meaningful use Stage 2, they would have to take into account what is possible using secure e-mail.

- Farzad Mostashari noted that this discussion also raises governance issues. Who owns the care plan? An analogy might be the complex query and being able to assemble and pull information from multiple places, and govern that. However, the more direct corollary to the Direct kind of transaction would be the simpler issue of closing the referral loop. That is much more tractable in the near term and does not involve changing health care delivery to be more coordinated.

- Paul Egerman said that the fundamental question is, are we designing quality measures based on data we have now or are we designing measures for what we want them to be, and driving the technology to them?

- Bechtel emphasized that patients want their doctors to talk to each other. The Workgroup should consider the parsimony that can be created between quality measures and the functional requirements of Stage 2. The care plan should be jointly owned by the patient and whichever provider on the patient's care team that he or she chooses.

Patient Safety

Lansky pointed to medication safety in particular. The adverse drug event was the most commonly suggested area of focus, as well as the area with the most methodology challenges. Other suggestions were chronic medication monitoring, complications of several kinds, hospital-oriented categories, falls assessment, and monitoring of falls.

With regard to methodologies, issues raised included how to measure adverse drug events, capturing relatively infrequent events and using them as part of a quality measure given the low rate of incidence, and whether measures have to be risk-adjusted for different settings and populations.

Discussion

- Neil Calman pointed out that one thing that differentiates this safety issue is that they are measuring things that should not happen, versus others areas in which they are looking at positive attributes. They are asking people to report on things that should not have happened. There is a clear sense that adverse drug reactions are grossly underreported. If they are going to do any kind of measurement, they should be encouraging people to try and use it. A mechanism is needed that makes it easy for providers to create, through their EHR system, the major components of a report and figure out a way to get that information transmitted quickly. A good measure may be the number of adverse drug events that are reported, and that makes it difficult because people are reporting what should not have happened. Adverse drug event reporting can be tied closely to decision support networks relating to the elderly and to pregnancy.

- Charles Kennedy pointed out that when there is a hospitalization due to an ambulatory adverse drug event, that information shows up on the claim for hospitalization. A measure around information on ambulatory events that are severe enough to require hospitalization could be created. He said that a methodological issue facing this effort involves considering what happens when one tries to explore where HIT could have avoided any of those events. Was an alert triggered? Was it acted upon? Different products manage the data for that process differently.

- Gayle Harrell pointed to Florida's Gold Standard Program, which measured adverse drug interactions. The methodology may not be consistent, but there is methodology available. She asked about the liability issue: who owns liability at the end of the day on these safety measures, and how these are going to be reported?

Population and Public Health

The most promising measures are looking at patients with undiagnosed hypertension by using calculated algorithms to get at underreported instances of hypertension. Another measure suggested was long assessments of blood glucose and blood pressures, taking readings across

two different time stamps. Also suggested was the ability to stratify quality measures by patient demographics, especially to get at equity and disparities issues.

Methodology issues include comparing traditional outcomes measurements of, for example, blood pressure, versus looking at this as a population health issue. The issues are around capturing data: how many recordings of blood pressure are there, which ones should be used, and how does one generalize at the population level? Also, some work is needed on data capture conventions for those.

Discussion

- Marc Probst commented that the measures presented are good, but are directed toward a population seen by an internist or an adult population in a family practitioner's office. He expressed hope that some of these measures would be applicable to pediatric practices. He suggested immunization rates and, in an obstetrics practice, the screening measures. He acknowledged that a parsimonious approach is desirable, but added that this set of measures is limiting.

- Lansky acknowledged this point, and also brought up specialty measures, wondering if they should they be population health-oriented.

- Connie Delaney said that one example of measures she was surprised not to see was something related to obesity, which would cross variety of populations and increase prevention. Another Committee member suggested screening for depression, and another added smoking status. It was noted that BMI and smoking measures are already a part of Stage 1 meaningful use, but not with a population health perspective.

- Gayle Harrell asked whether the Centers for Medicare and Medicaid Services (CMS) would be ready to accept reporting and evaluate it in order to determine that providers are meeting the measures.

- Judy Murphy said that the group should be focusing on prevention, because it will have the greatest effect in the future. Especially issues such as childhood obesity and immunizations, which will have some of the greatest effects in future years.

- Christine Bechtel pointed to the timeline for examining measure development. The ONC has said all along that improving outcomes is what it wants to focus on in Stage 3. One way to narrow the field of outcomes is to look at the national quality strategy, assuming that it is available in time for the ONC to make appropriate investments in those areas.

- Paul Egerman said that during the implementation hearing, one concern voiced was that the ONC is looking at its own work in isolation, without understanding the other activities providers have engage in for accreditation, and for other federal and state agencies. In particular, there is a series of quality reports that providers have to produce. His suggestion is that they need to clearly articulate why the ONC is doing something that is different. If this

cannot be articulated, then there may be some existing quality metrics that providers can use, because they are already doing the work to report on them.

5. Adoption/Certification Workgroup Update: Implementation Hearing and Upcoming Liability Hearing

Adoption/Certification Workgroup Chair Marc Probst described a hearing on implementation that was held in January. The Workgroup heard great appreciation for the work that was being done by this Committee and by the HIT Standards Committee (HITSC), and Probst indicated that he sensed an overall positive attitude by those who attended.

The Adoption/Certification Workgroup was asked to work together with the HITSC Implementation Workgroup, so this hearing was a hybrid effort. Adoption/Certification Workgroup member Larry Wolf was key in putting the hearing panels together. Wolf said that the panelists discussed the challenges, barriers, and successes in the areas of regional extension centers (RECs), EHR certification, health information exchange (HIE), eligible providers' experiences, and eligible hospitals. There was good representation from all over the country. He shared some of the major themes that arose from the hearing. For instance, the information learned at the hearing suggests that there is a great deal of awareness in the community about meaningful use.

Almost as an aside, a statement was made that physician malpractice insurance rates were increasing. The group had previously heard that some insurers were providing discounts to people using EHRs, so this was a surprising statement. This will likely be the topic of a separate hearing.

There was a distinction made between "using a system meaningfully" and "meaningful use." The groups at the hearing represented two different audiences: early adopters and those who are not already up and running with EHRs.

The early adopters have been using HIT for a long time: their plans were in place, meaningful use happened, and their world changed. Maybe the sequencing of their planning changed, maybe they have the right products but they are not running current versions, and now they will have upgrade to be certified, which was not part of their plan. Therefore, there was questioning about whether the meaningful use incentive program was accomplishing what is generally understood to be meaningful use "on the ground." Wolf said that a strong statement was made that users want to have a true replacement of what had been their 3-5 year strategic plans. There was encouragement for the ONC to spell out meaningful use Stage 3, and for using meaningful use Stage 2 as a bridge to get there. In this way, organizations can make a plan and align their resources.

Concern was voiced that systems are being created that can pass the test of certification, but not the more important test of actual workflow integration. Smoking cessation was a particular area of concern—there used to be methods for capturing that information, but the criteria was slightly different from what meaningful use requires. Therefore, a freestanding piece had to be added on, which does not integrate with anything else.

Regarding certification, situations are arising in which vendors have submitted a whole application for certification as a comprehensive EMR, but users were only implementing part of it, and using other products to fill in gaps. The question was asked, how is certification handled when products were not certified as modular, but people are using them in a modular way?

There was a general concern expressed about vendor viability through the remaining stages of meaningful use. Meaningful use Stage 1 triggered a forced upgrade cycle in order to get certified software. People are concerned about whether the makers of the software they are being compelled to buy will continue to be viable through the remaining stages of meaningful use.

RECs are beginning to address the population of people who are not already using EMRs. At the hearing, Workgroup members heard that RECs are not consistent, but there were several positive comments on their usefulness in getting organizations up and running with meaningful use quickly.

There was a fair amount of discussion related to defining standards. The fact that standards keep changing and new ones keep getting developed is frustrating. The Workgroup also heard that it primarily relates to the perception that there are changes to the certification rules when the rules are clarified.

There was also discussion about workforce worries. Wolf noted that one participant at the hearing commented that it is not difficult to find experts to work on meaningful use issues, but the cost of this work has doubled since last year.

The Workgroup pulled out the top recommendations from the hearing:

- Provide adequate time.
- Keep it simple. Don't let "perfect" be the enemy of "good enough."
- Keep the implementation cost as low as possible.
- Design for the "little guy."
- Pick a standard(s) soon.
- Address workforce issues.
- Increase the focus on usability.
- Improve choreography between federal agencies impacting HIT.
- Create a crosswalk between meaningful use and certification requirements.

Discussion

- Christine Bechtel asked that a comprehensive report be developed to summarize the hearing. Several other committee members spoke in favor of this. Specifically, Bechtel asked if they could take each recommendation and list the top two policy options for making those happen.

- With regard to quality measures being an issue, David Lansky asked for the specifics from the hearing, so that any mistakes are not repeated in meaningful use Stage 2. Wolf clarified that the issue in terms of quality measures expressed at the hearing was that there were too many, overlapping, and conflicting quality measures from too many different places.

- Gayle Harrell suggested going back to the individuals who commented at the hearing and asking them for their specific solutions.

- Marc Probst noted that another major theme at the hearing was the need for time to allow usability and workflow issues to evolve. People need time to develop solutions, get feedback, adjust, and move forward. Gayle Harrell concurred, adding that the time element has been an issue since the very first Workgroup meeting. There is a need to allow the markets to mature.

- Charles Kennedy referred to the expression, "quality, cost, and time—pick any two." Cost and time both seem relatively fixed for meaningful use, so he worries that they are setting up some potential quality issues. He asked, should they recommend an action such as going to Congress and suggesting that they need to take another look at the Health Information Technology for Economic and Clinical Health Act (HITECH) and provide more flexibility on time? Probst suggested the focus be on creatively using the time that has been allocated. He did acknowledge that more time would be beneficial, however.

- Of all the competing initiatives in the IT area, Probst said the most glaring is ICD-10. They are not competing in the sense that one technology is going to hurt another, but they are competing with regard to time and resources. It would be helpful for this group to be conscious of that and understand the scope of everything that is being asked of health care providers.

- Lansky suggested that the HITPC consider an update to the strategic plan that would give the country a second generation of guidance about what can be achieved in this 6-year window of meaningful use.

6. Privacy and Security Tiger Team Recommendations

Privacy and Security Tiger Team Co-Chairs Deven McGraw and Paul Egerman walked the Committee through a series of actions that the Tiger Team developed based on the recent hearing on patient matching. They noted that some of the solutions proposed are technical while others relate to workflow and other non-technical considerations.

The Tiger Team's recommendations are as follows:

- Recommendation 1: Standardized formats for demographic data fields.
  - There is agreement from providers that some level of standardization on commonly used data elements is critical. Name, date of birth, address, gender, etc. would be beneficial, but it is not a requirement to use those data elements for matching. These data formats already exist, in HL7 and many other places, but many organizations do not know exactly how to handle this issue. EHRs should be tested and certified for interoperability regarding these data fields. The HITSC should identify the standards that should be used, and they should be included in certification. The U.S. Postal Service validation/normalization program would be helpful in this process.

- Recommendation 2: Internally evaluating matching accuracy.
  - The Tiger Team heard many comments on fostering a culture of improvement within health care organizations with regard to matching accuracy as well as internally evaluating the efficacy of workflow strategies. Health care organizations should be evaluating the efficacy of their strategies on an ongoing basis, internally. Much work remains to improve the evidence base about what is effective, and to start generating best practices. As an initial starting point, this ought to be a priority for organizations to focus on. It is important for patient safety as well as privacy.

Paul Egerman pointed out that there does not appear to be a simple-to-use, well-recognized metric to measure accuracy. That by itself is a serious problem in defining this on a national basis. Also, he is not sure they could get to a one-size-fits-all measurement on accuracy. There are different challenges based on populations being served as well as the practice type.

- Recommendation 3: Accountability.
  - Linking patient accuracy may be a part of the bigger issue of all data accuracy. One way to handle it would be as part of a governance issue approach for information exchange. Matching accuracy should be enforced through the NHIN or HIE governance of the participating organization. HIEs will have some knowledge of the populations they serve, so they are in a position to establish thresholds for their organizations.

- Recommendation 4: Developing, promoting, and disseminating best practices.
  - The Tiger Team recommends that the ONC develop a program to disseminate information on the best practices on matching accuracy. Transparency programs should be established with regard to the efficacy of different algorithms, and where possible, funding should be given to the development of matching strategies.

- Recommendation 5: Supporting the role of the individual/patient.
  - Patients will have access to their own information, so they can point out errors and perhaps correct these themselves. The Tiger Team did not want to recommend patient portals for registration data, because the Meaningful Use Workgroup is working on this issue. The Privacy and Security Tiger Team supports the efforts of those other groups to increase patient access to their records; this matching issue is another reason why patient access is important.

Discussion

- David Lansky asked about issues of liability and accountability, given the potential variability that they have described from one region to another. He asked, what about the risk management and liability issues that would be faced by providers in a sloppy environment versus a more vigorous one? McGraw expressed the desire to evolve towards minimum thresholds, but said there was no evidence presented in the hearing about where to set those. There is so little research in the field that it may be premature to make those recommendations.

- Paul Egerman pointed out that a lot of health care organizations are so concerned about incorrect matching, and sending out incorrect data, that they tend to create false negatives, or duplicate records. Duplicate records mean that practitioners are not necessarily operating with the full set of data on a patient. Duplicate record rates are approximately 10% of all records in large organizations, he said.

- Larry Wolf asked if there were any insights on how to measure accuracy. He likened it to adverse drug reactions: they know about the really bad ones, but what about the "not so bad ones?" McGraw emphasized the need for creating a culture of improvement, and focusing attention at the national level on developing best practices and transparency from a measurement standpoint.

- In response to a question, McGraw said that when the Tiger Team made the technical recommendation about data fields being consistently expressed, they did not specify a requirement to use all the data fields in the process. There must be an iterative process, if the standard fields for identification (name, address, etc.) are not sufficient.

- One Committee member offered a different view on the threshold issue that can be seen in the HIE pilots that are underway. Rather than return false positives, they have set a threshold for a match that will not return any information if that threshold is not matched. This protects patient privacy, and also prevents those working in disability claims from relying on potentially inaccurate information for making decisions. HIEs have a vested interest in making sure false positives are not provided. A high incidence of false positives will create pressure on the HIEs from the providers, so there is a free market aspect to how accuracy is going to be dealt with in information exchange.

- Neil Calman explained that when looking for a patient in HIE, the more fields one puts in, the higher the chance is that there will be a mismatch. In an administrative process, that might not be such a terrible thing, but in a clinical context it might be exactly what a practitioner needs because they would not want to miss the information that would have been critically important at that moment. Also, in a situation in which a lab result gets transmitted automatically and matched, there should not to be a match unless there is a pretty good sense that the match really is to the correct patient. But if the patient is sitting right in front of the practitioner at the time, it would be a good opportunity to check a piece of information against them. It is incredibly important not to try to call out particular measures or

methodology, but to understand that it needs to evolve and will play out differently in different contexts.

- Judy Murphy pointed out that once the link is accurately made it should be maintained, so it does not have to be done a second time, through the technology underpinning the EHRs. This would decrease the potential for inaccuracy in the future.

Action Item #2: The recommendations of the Privacy and Security Tiger Team were accepted by consensus.

7. Information Exchange Workgroup Update

Workgroup Chair Micky Tripathi offered a status report on provider directories and an agenda-setting discussion for the development of a roadmap for the Information Exchange Workgroup over the next 6-9 months. The group has been working on provider directory issues since last August, staging recommendations into entity-level and individual-level provider directories. In December, entity- level provider directories were presented to and approved by this Committee. Some of the recommendations relating to providing direction to the Standards Committee were presented to the HITSC on January 12. That Committee is in the process of assigning the work to one of its workgroups. Walter Suarez, who was Co-Chair of the Information Exchange Workgroup, is also Co-Chair of the HITSC Privacy Workgroup, so the spirit of what they wanted to have expressed will be continued in the standards work.

The Workgroup is using the same framework for the individual-level provider directories that it used for the entity-level directories. They are now considering what the directory will look like. A Workgroup task force has developed a set of preliminary recommendations, and will discuss this further in coming meetings. The recommendations will be presented to the HITPC at its March meeting.

Entity-level provider directories were more complex than initially thought, and the individual level is even that much more complex, Tripathi said. The Workgroup had hoped to have recommendations for this meeting, but needed to address more issues than originally anticipated. Many of the forthcoming recommendations will be in the form of best practices, in acknowledgement that there are individual variations from state to state and region to region, relating to what how directories will be used, sustainability models, and other issues. The Workgroup wants to provide flexibility for that variation.

Looking ahead to meaningful use Stage 2 and information exchange issues, the Workgroup wants to take a lighter approach to a larger number of issues. It wants to be able to identify for each issue what might be the core areas worth exploring, offer quick recommendations for those, and then pausing and perhaps digging deeper where necessary. Also, it will start to engage with the Meaningful Use Workgroup, and formalize their input on the interoperability aspects of meaningful use, so that what the HITPC sees has been coordinated between the two Workgroups.

8. PCAST Report Workgroup Update

PCAST Report Workgroup Chair Paul Egerman explained that the Workgroup includes 18 experts with diverse backgrounds in the areas of privacy, technology and the internet. On December 8, 2010, the PCAST released a report, *Realizing the Full Potential of Health Information Technology to Improve Healthcare for Americans: The Path Forward*. On the same day, the ONC published a Request for Public Comment asking nine questions regarding the impact of PCAST on ONC activities, initial thoughts on the recommendations, and how they want the Office to act on the recommendations. Public comment was due on January 19. A total of 107 comments were received.

The 100-page PCAST report gives advice on a broad range of topics to the President. Egerman indicated that the President has read the report and suggested that all HITPC members read the report as well. The report includes statements indicating that the ONC needs to act aggressively, accelerate progress, and take bold steps around interoperability. It clearly states of a sense of urgency and priority around information exchange. The PCAST Report Workgroup will assist with analysis of public comment, discuss the implications of the report and its impact on ONC programs, and will examine the ONC strategic framework and consider whether any adjustments are necessary.

The Workgroup is not judging the report itself, but rather examining its recommendations and its impacts. Two months from now, the Workgroup will present its final report to the Policy Committee, and then to the HITSC. Members from both Committees will be invited to attend Workgroup-organized hearings on February 15-16.

Workgroup Co-Chair Bill Stead explained that PCAST provides directional recommendations, and then specific technical approaches as examples. The Workgroup's job is to understand and explain these directional statements, and then provide alternative suggestions for how they might be achieved for ONC's consideration. He presented the three major directions of the PCAST Report, which he said were identified by Egerman and himself, and not the full Workgroup:

- Accelerate progress toward a robust exchange of health information.

- Establish an exchange architecture with a universal exchange language, supporting infrastructure, and strong privacy and security safeguards. The exchange architecture will enable physicians and patients to assemble a patient's data across organizational boundaries, consistent with persistent patient privacy preferences.

- Establish an evolutionary transition that builds upon existing EHR installations and ONC's clinical document architecture (CDA).

He walked the group through the key exchange architecture concepts and offered to organize a conference call during the week following this meeting to ensure that Committee members understand the concepts.

Discussion

- Paul Egerman pointed out that one of the hearing's panels will focus on population health, which is a major theme within the PCAST report. Adam Clark emphasized that the Workgroup also has been trying to ensure that clinical trials are also incorporated.

- In answer to a question by Judy Murphy, Bill Stead explained that the PCAST report proposes an exchange infrastructure that would allow representation or tagging of information within a system with whatever semantic standard is appropriate, such as the ones that are already being worked through the ONC process. Users will be able to find, exchange, and then access those standards necessary to interpret the information, using concept-matching algorithms. This is not a top-down prescriptive model that would regularize the meaning of all data across the country.

- Gayle Harrell commented that the report suggests a different approach than the one that has been taken over the past 2 years. She expressed concern that the PCAST report may not have fully considered ongoing activities and the associated costs with changing course. Egerman explained that a large portion of the PCAST Report Workgroup's efforts will involve laying out the options to coordinate the PCAST report recommendations ONC activities, including existing programs.

9. Public Comment

- Tom Morrison of NaviNet explained that the PCAST report is reflective of some new directions in technology, and has some policy-level implications for this group. One of the assumptions they have been making is that data is what is being exchanged and the application is what is presenting the data. It is not possible to create an application that supports 80,000 elements. In a Web-based world, the application is not necessary, and that opens many possibilities for exchange. It also offers the ability to exchange information that has been defined by the source in terms of its presentation.

- Richard Singerman of TrustMed MD responded to a comment made regarding quality measures, noting that providers are still responsible for figuring out the process redesign to leverage HIT tools in order to reach quality measures, and that this is a significant undertaking. Regarding the PCAST Report, he suggested that organizations that utilize other technologies be invited into the discussion to introduce a greater level of nontraditional thinking.

- Chantel Rizollo from the American Hospital Association (AHA) spoke regarding lessons learned from the Implementation Workgroup. She pointed out that there is no statutory requirement mandating that meaningful use Stage 2 must start on October 12—that is up to CMS, which could recommend a later start date. She also discussed examples to illustrate how complex and unclear it is for hospitals to attest that they have a certified EHR. The ONC has told hospitals and physicians that they must possess EHR technology certified for all Stage 1 meaningful use objectives. That means that hospitals must put in place technology that may soon be out of date, even in areas where they have chosen to defer. The ONC also has indicated that hospitals must buy all modules of an EHR in order to meet

meaningful use, even if the hospital is using a different technology to carry out a particular function.

With regard to quality measurement, Rizollo said that measures need to be coordinated across federal quality reporting programs. Many new programs under House reform will directly address many of the measures being considered. For example, there is a separate payment policy on readmission, including payment penalties, so there is no need to include readmission measures in meaningful use; it would be redundant. In addition, hospital-acquired conditions are part of a specific financial penalties provision. Also, the AHA is against using the Health Care Assistant Program's Experience Certification in the EHR. This information is already being collected and reported in Medicare quality reporting. It is important that this data remain anonymous, and if the survey is linked to a patient's own record, that confidentiality comes into question.

Finally, Rizollo emphasized that Stage 2 and 3 quality measures need to be tested in the field for feasibility and clinical validity. Stage 1 measure specifications for hospital clinical quality were not field tested and the algorithms are not even tested. A vendor can be certified for clinical quality reporting even if their algorithms are not correct. All clinical quality measures for Stages 2 and 3 must be clinically verified.

SUMMARY OF ACTION ITEMS:

Action Item #1: Minutes from the December 13, 2010, HITPC meeting were approved by consensus, with corrections sent by Paul Tang to Judy Sparrow.

Action Item #2: The recommendations of the Privacy and Security Tiger Team were accepted by consensus.